KENTUCKY EMPLOYEES HEALTH PLAN

PY 2006

HEALTH INSURANCE APPLICATION FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION

Insurance Effective Date ☐☐/☐☐/☐☐☐☐ Company Number ☐☐☐☐☐☐

Deduction Start Date *(for **BOEs ONLY**)* ☐☐/☐☐/☐☐☐☐ Dual Employee Code ☐

Reason for Application

☐< New Employee ☐< Open Enrollment ☐< New Group
☐< COBRA ☐< FSA Only ☐< Previously Waived* ☐< Other*

* If you Previously Waived or marked "Other", enter the Qualifying Event Date AND a description of the Qualifying Event: Date _____ Description _____

SECTION I: DEMOGRAPHIC INFORMATION

PLEASE PRINT

SSN ☐☐☐-☐☐-☐☐☐☐ Date of Birth ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Smoking Status
Were you a smoker on 7/1/05? Yes ☐ No ☐

Name (First, MI, Last) _____

Marital Status
☐< Married
☐< Single

Gender
☐< Male
☐< Female

Street Address _____ PO Box / Apt. # _____

City, State, Zip Code _____ County of Residence _____ Country/Mail Code -- If NOT U.S.A. _____

( ) - Planholder's Primary Phone Number

Planholder's Email Address _____

/ / Hire Date

Employer Name _____ Work County _____

SECTION II: PLAN SELECTION

1. Plan Code ☐☐☐ *If electing coverage, enter 143 and complete this section. If waiving, enter 999 and go to Page 2.*

2. Option (Check only one)
☐< Commonwealth Essential
☐< Commonwealth Enhanced
☐< Commonwealth Premier

3. Level of Coverage
☐< Single ☐< Couple
☐< Parent Plus ☐< Family

4. Cross-Reference
☐< Yes
If Yes, you must complete Sections III and IV

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

If you elected Single in Section II, box 3, go to Section VI on Page 2.

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete ONLY if you checked Yes in Section II, box 4 above.

Company Number: *(REQUIRED)*	Dual Employee Indicator, if applicable:	Was spouse a smoker on 7/1/05? *(REQUIRED)*	Is spouse a Hazardous Duty Retiree?	Spouse's Hire Date or Retirement Date:	Spouse's Deduction Start Date (If BOE employee):
☐☐☐☐☐	☐	☐ Yes ☐ No	☐ Yes ☐ No	/ /	/ /

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if you or your spouse have a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number ☐☐☐-☐☐-☐☐☐☐

☐☐☐-☐☐-☐☐☐☐

Custodial Parent Name _____ All Dependents? ☐< Yes

Custodial Parent Address _____ Country / Mail Code (If not USA) _____

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SECTION VI: FLEXIBLE SPENDING ACCOUNT

Planholder's SSN

For state employees ONLY (Commonwealth Choice participants). Employees of a Board of Education, a Health Department or a Quasi agency must contact their Insurance Coordinator regarding the FSA enrollment process and deadlines.

Health Care Flexible Spending - All contributions and limits are "per paycheck".

Minimum allowable combined contribution per employee is $5 **Maximum** allowable combined contribution per employee is $120

PLANHOLDER

Employer Contribution if waiving coverage: _____
(Amount will be reduced by $17 per paycheck on July 1, 2006)

Participant Contribution _____

Expected paychecks X _____

Total Participant Contribution for Plan Year = _____

HumanaAccess℠

Upon enrolling in a Health Care Flexible Spending Account, you will receive the HumanaAccess℠ debit card at no cost to you and with no transaction fee.

SPOUSE *-- If paying by cross-reference and spouse's employer participates in the state's FSA Program*

Spouse Contribution _____

Expected paychecks X _____

Total Spouse Contribution for Plan Year = _____

HumanaAccess℠

Upon enrolling in a Health Care Flexible Spending Account, you will receive the HumanaAccess℠ debit card at no cost to you and with no transaction fee.

Dependent Care -- All contributions and limits are "per paycheck".

Minimum - $5 **Maximum** - based on tax filing status

TAX FILING STATUS: ☐ < Married, filing separately (max - $104) ☐ < Married, filing jointly (max - $208) ☐ < Single, head of household (max - $208)

PLANHOLDER

_____ (Participant Contribution) X _____ (Expected paychecks) = _____ (Total Contribution for Plan Year)

SPOUSE *-- If paying by cross-reference and spouse's employer participates in the state's FSA Program*

_____ (Spouse Contribution) X _____ (Expected paychecks) = _____ (Total Contribution for Plan Year)

SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself and the Department for Employee Insurance.
* I understand that if my spouse and I pay by cross-reference, our plan can not change if one of us terminates employment.
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* I agree to abide by the terms and the conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* I elect to participate in the Premium Conversion Program unless I sign the cancellation form. [See the Health Insurance Handbook for details.]
* I understand that enrollment in a FSA is optional and that by completing Section VI of this application, I am enrolling in a FSA, if eligible to participate.
* Regarding my FSA, I understand that any dependents I claim reimbursement for are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my FSA, I further understand that any unused amount remaining in my Spending Account at the conclusion of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
* I understand that I have a 90 day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I have read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ Employee Signature _____ Date

_____ Spouse Signature - ***REQUIRED if electing to pay by cross-reference*** _____ Date

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the state-sponsored health insurance plan. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ Employee's Insurance Coordinator Signature _____ Date

_____ Spouse's Insurance Coordinator Signature - ***REQUIRED if electing to pay by cross-reference*** _____ Date

HEALTH INSURANCE APPLICATION FOR ACTIVE EMPLOYEES - Instructions -- PAGE 1

Reason for Application

- New Employee: Check this box if you are a new employee.
- Open Enrollment: Check this box if you are filling out this application for Open Enrollment.
- New Group: Check this box if your employer is joining the Kentucky Employees Health Plan for the first time.
- COBRA: Check this box if you are applying for COBRA coverage (Your Insurance Coordinator will mail this application and your initial payment).
- FSA Only: Check this box if you are enrolling in a Flexible Spending Account for the first time due to a Qualifying Event.
- Previously Waived: Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event (QE) that allows you to select coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an Add or Drop form only. You may request an Add or Drop form from your Insurance Coordinator (IC) and must provide supporting documentation, as required.
- Other: Check this box if none of the listed options apply. The IC must provide a date and an explanation if "Other" is selected.

TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.
For ALL employees - Enter the effective date of coverage and the employee's company number.
For BOE employees only – Enter the Deduction Start Date.
For STATE employees only - Enter the dual employee indicator, if applicable. Leave blank if not a dual employee.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the planholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Smoking Status, Marital Status, Gender, Planholder's Primary Phone Number, Planholder's Email Address, if available, Hire Date, Employer's Name and Work County. **Note:** If the smoking status flag is not checked, this application will be Pended until the information is provided.

SECTION II: PLAN SELECTION

1. Plan Code: If electing coverage, enter 143. If waiving coverage, enter 999.
   WAIVING your health insurance DOES NOT automatically direct your money into a Flexible Spending Account (FSA). To enroll in a FSA, state employees must complete Section VI. All others must contact their IC for information about their FSA Program.
2. Option: Mark the option you are selecting. For a description of each option, see the Health Insurance Handbook. Select only one.
3. Level of Coverage: Mark the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. Select only one.
4. Cross-reference: If you wish to pay by cross-reference, check Yes and complete Sections III and IV. ONLY ONE application is required to pay by cross-reference. The person listed in *Section I: Demographic Information* will be the planholder.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Provide the information requested for every dependent you are enrolling (including your spouse if electing the cross-reference payment option). If you need additional space, use Page 1 of another health insurance application.

Relationship Code: Enter the appropriate relationship code as follows:

SP Spouse (your eligible spouse).
CH Child (your eligible child, step child, adopted child, foster child or your grandchild) age 0 to 24 (To enroll, a dependent must be age 23 or less and not turn 24 during the coverage year).
DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.
CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance) and that is not claimed as a dependent on the member's tax returns.

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are electing to pay by cross-reference. Enter your spouse's company number (required), dual employee indicator (if applicable), smoking status (required), hazardous duty retiree indicator, hire date or retirement date (if applicable), and the deduction start date (only needed if the planholder elects to start a cross-reference payment method with an employee of a Board of Education).

SECTION V: CUSTODIAL PARENT INFORMATION

Complete this section if you have a Court Order or an Administrative Order to provide health insurance for an eligible dependent. Enter your dependent's social security number and the custodial parent's name and address. If the custodial parent is the same for each dependent, check the Yes box for "All Dependents?" and complete the custodial parent's name and address only once. If the custodial parent is different for each dependent, complete the appropriate information using an additional page. Court Ordered dependents MUST be listed in Section III.

HEALTH INSURANCE APPLICATION FOR ACTIVE EMPLOYEES - Instructions -- PAGE 2

Enter the social security number of the planholder in the spaces provided on the top right hand corner of Page 2.

SECTION VI: FLEXIBLE SPENDING ACCOUNT (FSA)

- This section can only be completed by employees of state agencies that participate in the state's FSA program (Commonwealth Choice).
- If you are an employee of a Board of Education, Health Department or Quasi-governmental agency, you cannot use this section to enroll in a FSA. You must contact your IC regarding your FSA enrollment process and deadlines.
- Enrollment in a FSA is optional. In order to waive coverage and direct the available employer contribution into a FSA you must enroll, either online (during open enrollment) or by completing this section (for state employees) by the deadline.
- All amounts entered in this section are "per paycheck".

Health Care Spending Account

PLANHOLDER

Employer Contribution if waiving coverage: If you are waiving your health insurance coverage, enter $117. This is the employer contribution per paycheck for January 1, 2006 through June 30, 2006. From July 1, 2006 through December 31, 2006, the employer contribution will be $100 per paycheck. This amount will be adjusted automatically. If you are electing coverage, enter 0 or leave blank.
Participant Contribution: Enter the amount that you want deducted from each paycheck.
Sub-Total: Add the Employer Contribution and the Participant Contribution. This amount must not exceed $120.00 per paycheck.
Expected Paychecks: Enter the number of expected paychecks.
Total Participant Contribution for Plan Year: Enter the total participant contribution amount for the entire coverage period.
Humana*Access*: If you are eligible and elect to participate in the Flexible Spending Account Program offered to employees of state agencies, you will receive the Humana*Access* card at no cost to you and with no transaction fee. This is a free service available to you.

SPOUSE (For cross-reference payment option only)

Complete this section with YOUR SPOUSE'S Flexible Spending Account information, only if your spouse meets ALL of the following:

- He/she is a state employee (agency participates in Commonwealth Choice);
- He/she is electing to pay by cross-reference; and
- He/she is electing to enroll in the available FSA program. Enrollment in a Flexible Spending Account is OPTIONAL.

Spouse Contribution: Enter the amount that your spouse wants deducted from each of his/her paychecks.
Expected Paychecks: Enter the number of your spouse's expected paychecks.
Total Spouse Contribution for Plan Year: Enter the total contribution amount for the entire coverage period.
Humana*Access*: If you are eligible and elect to participate in the Flexible Spending Account Program offered to employees of state agencies, you will receive the Humana*Access* card at no cost to you and with no transaction fee. This is a free service available to you.

Dependent Care Account

Mark the tax filing status that applies to you (or to both of you if your spouse is eligible and is also enrolling).

PLANHOLDER

Participant Contribution: Enter the amount that you want deducted from each paycheck.
Expected paychecks: Enter the number of expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period.

SPOUSE (For cross-reference payment option only)

Spouse Contribution: Enter the amount that your spouse wants deducted from each of his/her paychecks.
Expected paychecks: Enter the number of your spouse's expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period.

SECTION VII: AUTHORIZATION AND CERTIFICATION

- Read the statements in this section carefully. After you have read and understood the statements, sign your name on the "Employee Signature" line and enter today's date in the line provided. If you are applying to pay by cross-reference, your spouse MUST also sign the application on the "Spouse Signature" line. He/she must also enter today's date in the line provided.
- Your cross-referenced spouse must have his/her IC sign this form before you return it to your insurance coordinator.
- Your cross-reference application will not be processed without the four required signatures and dates: policyholder, spouse, planholder's insurance coordinator and spouse's insurance coordinator.

REMEMBER THAT YOU HAVE THE NEW OPTION TO ENROLL ONLINE. ENROLLING ONLINE IS EASY, FAST AND SECURE. IF YOU ENROLL ONLINE, YOU WILL RECEIVE INSTANT CONFIRMATION THAT YOU HAVE ENROLLED!